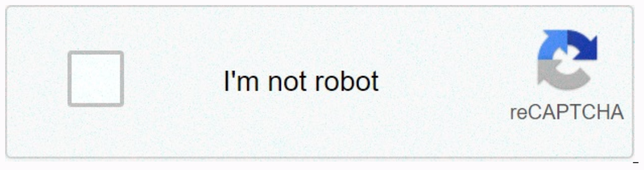


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# Acog gdm screening guidelines

The effect of increased ketolate on maternal and infant outcomes of pregnant women with abnormal glucose metabolism during pregnancy. Qian M, Wu N, Li L, Yu W, Ouyang H, Liu X, He Y, Al-Mureish A. Qian M, et al. Diabetes Metab Syndr Obes. 2020 25.15.13.4581.4588. doi: 10.2147/DMSO. S280851. 2020. Diabetes Metab Syndr Obes. 2020. PMID: 33268998 Free PMC article. Review. Up to 7% of pregnancy is complicated by diabetes mellitus, and the rate of gestational diabetes increases worldwide with an increase in obesity and sedentary lifestyle. Gestational diabetes increases the risk of gestational hypertension, preeclampsia, cesarean birth, and the development of diabetes later in life. There is a debate about the diagnosis and treatment of gestational diabetes, even with extensive studies on the subject. The American College of Obstetricians and Gynecologists (ACOG) has issued guidelines that provide recommendations based on quality research and identify current knowledge gaps. Gestational diabetes should be treated with nutritional therapy. If necessary, drugs should also be used for the benefit of the mother and fetus. Studies show a significant reduction in serious complications in the treatment of gestational diabetes. Nutrition therapy includes nutritional counseling, a personalized nutrition plan and a moderate exercise program to achieve normoglycemia, prevent ketosis, facilitate adequate weight gain and contribute to fetal well-being. If the target glucose levels can not be met only with the help of nutritional therapy, medical treatment should be started. There is no conclusive evidence to lead when to start medication. Although insulin was a standard medical therapy for gestational diabetes, insulin and oral drugs (e.g. glyburid, metformin [Glucophage]) are equally effective and suitable for first-line treatment. LIMITED OR INCONSISTENT EVIDENCEAll pregnant women should be screened for gestational diabetes using a history, clinical risk factors or glucose tests. Screening for gestational diabetes usually occurs after 24 to 28 weeks of pregnancy. Early screening is recommended in women with risk factors (i.e. history of gestational diabetes, known glucose metabolism disorders, or obesity [body mass index of 30 or more]). If the results of early screening are negative, screening should be repeated after 24 to 28 weeks of pregnancy. The screening approach widely used in the United States includes initial measurement of venous glucose one hour after administration of 50 g of oral glucose solution. Women who meet or exceed the screening threshold in the initial test will then undergo a 100 g three-hour oral glucose tolerance test. Although there are insufficient data available in cases of suspected macrosomy to reduce birth trauma that could be recommended for or against caesarean section, macrosomy is more common in gestational diabetes and Dystonia is more common in larger newborns whose mothers have gestational diabetes. Therefore, it is reasonable to discuss the possibility of caesarean birth if gestational diabetes is diagnosed and the weight of the fetus is estimated at 4,500 g (9 lb, 15 oz) or more. Consensus and expert opinionThe response values for the hourly glucose challenge ranged from 130 mg per dl (7.2 mmol per l) to 140 mg per dl (7.8 mmol per l), indicating different sensitivities and specifics. Since there is no clear evidence of determining the best threshold, physicians should choose either 135 mg per dl (7.5 mmol per L) or 140 mg per dl as one consistent cutoff for their practice. Factors such as the community prevalence of gestational diabetes should be considered in the decision. Similarly, no set of diagnostic criteria for a three-hour oral glucose tolerance test can be recommended. Physicians should choose one set of diagnostic criteria for consistent use in their practice: plasma plasma or serum glucose levels determined by the Carpenter and Coustan criteria, or plasma levels determined by the National Diabetes Data Group. After the diagnosis of gestational diabetes and the start of nutrition treatment, blood glucose levels should be monitored to determine whether glucose levels are adequately controlled. Although there is not enough evidence to determine the optimal frequency of glucose monitoring, the general recommendation is four times a day (fasting and one or two hours after each meal). Monitoring can be adjusted after glucose levels are well controlled by diet. Women with gestational diabetes who have good glycemic control and no other complications can be treated as expected. Most women with good glycemic control for medical therapy do not require childbirth before 39 weeks of pregnancy. All women with gestational diabetes should be screened six to 12 weeks after birth for diabetes, fasting glucose disorder or impaired glucose tolerance. Women with positive screening outcomes should be referred for preventive treatment and women with negative screening outcomes should be subdued every three years. For postpartum screening, a plasma glucose test or a two-hour oral fasting plasma glucose tolerance test is suitable. Source of instructions: American College of Obstetricians and GynecologistsUsed video evaluation system? YesLiterature search is described? YesGuideline developed by participants without relevant financial ties to industry? Not reported published source: Obstetrics & Gynecology, August 2013As available at: 2SAs Preventive Services Task Force (USPSTF) recommends screening for hepatitis C virus infection (HCV) in people at high risk of infection. The USPSTF also recommends offering adults between 1945 and 1965 (Table 1). B recommendations. For more information on hcv infection risk factors, see clinical considerations. HCV is the most common chronic blood borne pathogen in the United States and the leading cause of complications from chronic liver disease. The prevalence of antibodies to HCV in the United States is approximately 1.6% in non-institutionalized individuals. According to data from 1999 to 2008, approximately three quarters of patients in the United States with HCV infection were born between 1945 and 1965 with a highest prevalence of 4.3% in 0 to 49 years from 1999 to 2002,1,2 The most important risk factor for HCV infection is the use of injectable or current injectable drugs, with most studies reported a prevalence of 50% or more. The incidence of HCV infection was more than 200,000 cases a year in the 1980s, but decreased to 25,000 cases a year by 2001. According to the Centers for Disease Control and Prevention, there were an estimated 16,000 new cases of HCV infection in 2009 and an estimated 15,000 deaths in 2007. Hepatitis C-related end-stage liver disease is the most common indication for liver transplantation in U.S. adults, representing more than 30% of cases. Studies suggest that approximately half of the recently observed triple increase in hepatocellular carcinoma is related to acquiring HCV infection two to four decades earlier.1DETECTIONOsPSTF found sufficient evidence that antibody testing against HCV followed by confirmatory testing of polymerase chain reaction accurately detects chronic HCV infection. In screening strategies targeting people with risk factors for HCV infection (such as past or present drug use, injecting drug sex or blood transfusions prior to 1992), antibody testing against HCV is associated with high sensitivity (higher than 90%) and the small numbers needed to identify one case of HCV infection (less than 20 people).1 Antibody testing against HCV remains highly accurate in low prevalence populations, although the number needed to detect one case of HCV infection is higher. The USPSTF also found sufficient evidence that various non-invasive tests have good to very good diagnostic accuracy in diagnosing fibrosis or cirrhosis.3BENEFITS DETECTION AND EARLY INTERVENTIONSPSTF found no direct evidence of the benefit of screening for HCV infection in asymptomatic adults in reducing morbidity and mortality. However, the USPSTF found sufficient evidence that antiviral regimens resulted in a sustained virological response and improved clinical outcomes. The USPSTF found insufficient evidence that advising or immunizing patients with HCV infection against other infections improves health outcomes, reduces HCV transmission, or changes high-risk behavior. The USPSTF did not find sufficient evidence that knowledge of the positive state of HCV reduces high-risk behaviour. The USPSTF also found insufficient evidence that labor management and breastfeeding strategies in HCV-positive women are effective in reducing the risk of transmission from mother to child. Due to the accuracy of the screening test and the availability of effective interventions for HCV infection, the USPSTF concludes that screening has a slight benefit for populations at high risk of infection. The USPSTF concludes that one-time screening in all adults in the United States born between 1945 and 1965 is also a modest benefit. DAMAGE DETECTION AND EARLY INTERVENTIONOSPSTF found limited evidence of damage to HCV screening. Potential screening harms include anxiety, patient tagging, and feelings of stigmatization. The USPSTF found sufficient evidence of the damage associated with the diagnostic evaluation used to manage treatment decisions (liver biopsy). These damages include bleeding, infection, and severe pain in approximately 1% of people who had liver biopsies and deaths in less than 0.2%. However, the use of liver biopsies to drive treatment decisions decreases, and noninvasive tests have sufficient accuracy to diagnose fibrosis and cirrhosis. Thus, the absolute risk to people who are currently receiving a diagnosis of HCV infection and subsequent treatment is likely to decrease. The USPSTF found adequate evidence that antiviral therapy regimens are associated with high rates of damage such as fatigue, headache, flu-like symptoms, haematological events, and rash. However, antiviral therapy is given for a defined period of time, serious side effects are uncommon and side effects are limited and usually disappear after discontinuation of treatment. The USPSTF has found sufficient evidence that these harm treatments are small. The USPSTF ASSESSMENTSUSPSTF concludes with moderate certainty that screening for HCV infection in adults at increased risk of infection and one-off screening in adults in the 1945-1965 birth cohort has a modest net benefit. This recommendation applies to all asymptomatic adults without known liver disease or functional abnormalities. RISK ASSESSMENT The most important risk factor for HCV infection is drug use in the past or present. Another established risk factor for HCV infection is the intake of blood transfusions before 1992. Due to the implementation of screening programs for donated blood, blood transfusions are no longer an important source of HCV infection. By contrast, 60% of new HCV infections occur in people who report injecting drug use within the last six months.1Adative risk factors include long-term haemodialysis, birth of a mother with HCV infection, incarceration, intranasal drug use, obtaining unregulated tattoos and other percutaneous exposures (for example, in healthcare professionals or from surgery before the introduction of universal preventive measures). tattoos and other percutaneous exposures, as the risk factors for HCV infection are limited. The relative importance of these additional risk factors may vary based on geographical location and other factors.1Lare population studies report an independent link between high-risk sexual behavior (multiple sexual partners, unprotected sex, or sex with a person who has HCV infection or with an injecting drug user) and HCV infection. However, HCV appears to be ineffectively transmitted through sexual contact, and observed associations may be shamed by other high-risk behaviors. In 1998, the highest prevalence of antibodies to HCV occurred in people with significant direct percutaneous exposures, such as injecting drug users and people with haemophilia (60% to 90%); those with less significant percutaneous exposures, which included smaller amounts of blood, such as patients taking haemodialysis (10% to 30%), had a milder prevalence rate. Persons engaged in high-risk sexual behaviour (1% to 10%); recipients of blood transfusions (6%); and those with rare percutaneous exposure; such as healthcare professionals (1% to 2%), had the lowest prevalence rate.4.5 Among patients with abnormal liver function test results (measurements of aspartic transaminase, alanine transaminase or bilirubin) who were tested for reasons other than HCV screening, finding out the cause of the abnormality often involves testing for HCV infection and is considered a case finding rather than screening; , is outside the scope of this Recommendation. In 2010, the overall incidence of acute HCV infection was 0.3 cases per 100,000 people and varied by race or ethnicity. The incidence of acute hepatitis C was lowest among people of Asian or Pacific descent and highest among Indian and Alaskan natives. Blacks had the highest mortality rates from HCV, 6.5 to 7.8 deaths per 100,000 people, according to data from 2004 to 2008.6BIRTH-COHORT SCREENINGPersons born between 1945 and 1965 are more likely to that they will be diagnosed with HCV infection, possibly because they received blood transfusions prior to screening in 1992 or have a history of other risk factors for exposure decades ago.2 Many people with chronic HCV infection are unaware of their condition. The risk-based approach may omit the detection of a substantial part of people with HCV infection in the birth cohort due to a lack of patient information or knowledge of the previous risk status. As a result, a one-time screening for HCV infection in the birth cohort can identify infected patients in the early stages of the disease who could benefit from treatment before complications from liver damage develop. The USPSTF concluded that the benefit of screening for HCV infection in people in the birth cohort is likely to be similar to with a higher risk of infection. Birth cohort screening is probably less effective than risk-based screening, which means more people will need to be examined to identify one patient with HCV infection. However, the total number of Americans likely to benefit from birth cohort screening is higher than the number who will benefit from risk-based screening. The USPSTF recognizes that increased screening and the resulting increased diagnosis and treatment could result in increased overall harm because not all treated individuals will benefit from treatment, including those who never develop signs or symptoms of the disease (overdiagnosis). The USPSTF has considered this potential harm against potential under-damage that can be attributed to subdiagnostic. Future research is expected to reduce over-treatment by clarifying which people are most likely to benefit from early diagnosis and treatment. However, given that people in the birth cohort have been living with HCV infection for 20 years or more, the potential benefits of screening and early treatment will likely be highest now and in the near future before the decline. After considering the competitive damage of overtreatment and subdiagnoses, the USPSTF recommends a one-time screening of this cohort. SCREENING TESTSAnti-HCV antibody testing followed by testing for polymerase chain reaction to viremy is accurate for identifying patients with chronic HCV infection. Various non-invasive tests with good diagnostic accuracy are possible alternatives to liver biopsy for diagnosing fibrosis or cirrhosis. SCREENING INTERVALSPersons in the birth cohort and those at risk due to possible exposure to universal blood screening and otherwise not at increased risk must be examined only once. Persons at continued risk of HCV infection (injecting drug users) should be regularly examined. The USPSTF found no evidence of how often screening should take place in people who continue to be at risk of new HCV infection. SCREENING IMPLEMENTATIONESPSTF considers that screening should be voluntary and should only be carried out with the patient's knowledge and in the knowledge that HCV testing is planned. Patients should be informed orally or in writing that HCV testing will be carried out if opt-out screening does not subside. Furthermore, the USPSTF considers that prior to HCV screening, patients should receive an explanation of how HCV infection can (and cannot) be obtained, the importance of positive and negative test results, and the benefits and harms of treatment. Patients should also be offered the opportunity to ask questions and refuse testing. TreatmentThe goal of antiviral drugs is to prevent long-term health complications of chronic HCV infection (e.g. cirrhosis, liver failure, hepatocellular carcinoma). The combination of pegylized interferon (alpha-2a or alpha-2b) and is the standard treatment for HCV infection. In 2011, the U.S. Food and Drug Administration approved protease inhibitors boceprevir and telaprevir to treat genotype 1 HCV infection (the predominant genotype in the United States). Studies have found an increased rate of sustained virological response in patients with genotype 1 HCV infection who received triple treatment consisting of pegyl interferon, ribavirin and boceprevir or telaprevir compared to dual treatment consisting of pegyl interferon and ribavirin. There is no evidence of comparative effects of current antiviral therapy on long-term clinical outcomes. Regimens with protease inhibitors are usually shorter than dual therapies (24 or 28 weeks vs. 48 weeks). Triple treatment with protease inhibitors is associated with an increased risk of haematological events (e.g. anemia; neutropenia; thrombocytopenia, especially boceprevir) and rash (telaprevir) compared to dual treatment. These side effects are limited and usually disappear after discontinuation of treatment.7

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